



## PHYSICAL THERAPY REFERRAL

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Patient Name: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Frequency/Duration:  Daily  1 x Week  2 x Week  3 x Week  \_\_\_\_ Weeks

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### EVALUATION & TREATMENT

- |   |                                     |                                       |  |
|---|-------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Cervical                   | <input type="checkbox"/> Knee       | <input type="checkbox"/> Wrist/Hand   | <input type="checkbox"/> Dry Needling    |
| <input type="checkbox"/> Thoracic                   | <input type="checkbox"/> Ankle/Foot | <input type="checkbox"/> Home TENS    | <input type="checkbox"/> Virtual Reality |
| <input type="checkbox"/> Lumbar                     | <input type="checkbox"/> Elbow      | <input type="checkbox"/> Balance/Gait | <input type="checkbox"/> Pre-hab         |
| <input type="checkbox"/> Hip                        | <input type="checkbox"/> Shoulder   | <input type="checkbox"/> Tens         | <input type="checkbox"/> Pain Squad      |
| <input type="checkbox"/> Functional Movement Screen |                                     |                                       |  |
| <input type="checkbox"/> Other: _____               |                                     |                                       |  |
- 

Provider Name: \_\_\_\_\_

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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*Partnered with*  
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Lawton, OK 73505  
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Oklahoma City, OK 73170  
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